EXHIBIT 2

Attachment A – Data Fields

1. For Manufacturer Payments data and Documents, the data fields and documents produced shall include, but not be limited, to data and Documents sufficient to show:

    a. the total Manufacturer Payments received by You or Your Affiliates from each of the Manufacturer Defendants relating to claims by each Plaintiff's Health Plan beneficiaries for Diabetes Medications;

    b. how such Manufacturer Payments were categorized (e.g., rebates, consulting fees, clinical program fees, administrative fees, financial incentives, formulary-placement or access fees, inflation or price-protection fees, etc.);

    c. the portion of those Manufacturer Payments paid to or otherwise passed through to such Plaintiff;

    d. the total amounts paid to or otherwise retained by any Rebate Aggregator or Plan Sponsor Consultant relating to claims by such Plaintiff's Health Plan beneficiaries for Diabetes Medications;

    e. The total amounts paid by You to any of Your Affiliated pharmacies in connection with claims by such Plaintiff's Health Plan beneficiaries for Diabetes Medications;

    f. The total amounts paid by You to any non-Affiliated pharmacies in connection with claims by such Plaintiff's Health Plan beneficiaries for Diabetes Medications;

    g. The total revenues and profits earned by You or any of Your Affiliated pharmacies, including mail-order or specialty pharmacies, in connection with claims by such Plaintiff's Health Plan beneficiaries for Diabetes Medications; and

    h. The total amount paid to You by such Plaintiff in connection with Your pharmacy-benefit management services.

2. Claim Number (the number assigned to the claim or encounter filled by the pharmacy);

3. Claim Sequence (if available, the sequence or suffix of the claim which is used as the claim is adjusted or adjudicated);

4. Original Claim Number (if needed for adjustments, the original claim number to group a set of claims instances);

5. Base Claim Number (the "base" or "root" of a claim without any prefixes or suffixes, used to properly identify a set of claims);

6. Claim Status (the adjudication status of the claim, i.e., paid, reversed, adjusted, void, denied, etc.);

7. Rx Number (the number of the prescription being prescribed by the doctor);

8. Fill Number (the iteration of the number of times the prescription has been filled);

9. New or Refill (indicator if the prescription is new (first time filled) or a refill of an existing prescription);

10. Unique Patient ID (Your internal ID used to match between eligibility and claims);

11. Policy Number (the number which links all members together for a policy);

12. Dependent Number (the individual number/identifier of the patient);

13. First Name (first name of the patient);

14. Last Name (last name of the patient);

15. Date of Birth (date of birth of the patient);

16. Group Name;

17. Group Number;

18. Plan Description;

19. Line of Business;

20. Any other fields that can be used to identify or describe the PBM or plan name who was billed or paid for the claim;

21. Indication if the claim was paid for fully by the patient (Cash) and was not billed or any monies applied to the payment by insurance or any other entity or assistance program, including but not limited to manufacturer rebates, discounts, or chargebacks;

22. Prescriber Number (Your internal provider identifier for the prescribing party);

23. Prescriber NPI Number (the industry standard NPI number for the prescribing party);

24. Prescriber DEA Number (the industry standard DEA number for the prescribing party);

25. Prescriber name (the full name of the doctor or provider that prescribed the prescription);

26. Prescriber Address 1;

27. Prescriber Address 2;

28. Prescriber City;

29. Prescriber State;

30. Prescriber ZIP;

31. Dispensing Pharmacy Number (Your internal identifier for the pharmacy where the prescription was filled);

32. Dispensing Pharmacy NPI Number (the industry standard NPI number for the pharmacy where the prescription was filled);

33. Dispensing Pharmacy NCPDPID (the industry standard DEA number for the pharmacy where the prescription was filled);

34. Dispensing Pharmacy Chain ID (if the pharmacy is part of a chain, then the identifier for the parent corporation);

35. Dispensing Pharmacy Name (the name of the pharmacy where the prescription was filled);

36. Dispensing Pharmacy Address 1;

37. Dispensing Pharmacy Address 2;

38. Dispensing Pharmacy City;

39. Dispensing Pharmacy State;

40. Dispensing Pharmacy ZIP;

41. Billing Pharmacy Number (Your internal identifier for the pharmacy where the prescription was filled);

42. Billing Pharmacy NPI Number (the industry standard NPI number for the pharmacy where the prescription was filled);

43. Billing Pharmacy NCPDPID (the industry standard DEA number for the pharmacy where the prescription was filled);

44. Billing Pharmacy Chain ID (if the pharmacy is part of a chain, then the identifier for the parent corporation);

45. Billing Pharmacy Name (the name of the pharmacy where the prescription was filled);

46. Billing Pharmacy Address 1;

47. Billing Pharmacy Address 2;

48. Billing Pharmacy City;

49. Billing Pharmacy State;

50. Billing Pharmacy ZIP;

51. Date the prescription was written;

52. Date the prescription was filled;

53. Date the claim was adjudicated;

54. GPI Number (the Generic Product Identifier being billed for the dispensed drug);

55. Full 11-digit NDC;

56. Drug label name (the name of the drug as it would appear on the manufacturer's label on the bottle);

57. Drug strength (amount of drug in the dosage form or a unit of the dosage form (e.g., 500 mg capsule, 250 mg/5mL suspension, etc.));

58. Drug Manufacturer;

59. Payment Basis (if available, the pricing system utilized for payment calculations (e.g., AWP, MAC, FUL, billed amount, usual & customary));

60. Dispenser Type Code, if available, and descriptions of those codes (e.g., indicates if the claim was filled at retail or mail order);

61. Ingredient cost (i.e., the amount charged to the payer(s) by the pharmacy for the pharmaceutical product, exclusive of the dispensing fee);

62. Pharmacy's billed amount (among the provider is billing to the insurance carrier, may also be known as Usual and Customary Charge, Gross Amount Due or Submitted Ingredient Cost + Dispensing Fee);

63. Dispensing fee paid;

64. Insurance Allowed Amount (the maximum amount the insurance carrier is allowed to pay based on the policy's network and plan coverage);

65. Insurance Plan Paid Amount (amount the insurance carrier paid to the provider);

66. Member Responsibility Amount (amount the individual member was responsible for paying to the provider (deductible, copay, coinsurance, etc.));

67. Any and all fields that are associated with and describe the Member Responsibility Amount;

68. Total Paid Amount (the total amount the provider was paid for this claim related to this insurance policy);

69. Other Insurance Paid Amount (any additional known payment made to the provider by a third party or other insurance policy);

70. Identifier and description of the Other Insurance that made payment on the claim;

71. Quantity dispensed;

72. Quantity prescribed;

73. Days supply;

74. Sales tax (if applicable);

75. Incentive amount paid (i.e., a contractually agreed upon incentive amount that is paid to the pharmacy for services rendered);

76. Amount attributed to processor fee (i.e., an amount charged to the pharmacy by either the health plan or PBM as a transaction fee);

77. Amount attributed to product selection/brand drug (i.e., an amount added to the member responsibility based on using a Brand Name product when a generic is available);

78. Amount attributed to product selection/non-preferred formulary selection (i.e., an amount added to the member responsibility based on using a nonpreferred product when a formulary alternative is available);

79. Amount attributed to product selection/brand non-preferred formulary selection (i.e., an amount added to the member responsibility based on using a non-preferred Brand Name product when a formulary Brand Name product or generic product is available);

80. Information sufficient to determine if the patient payment was based on a flat tiered co-payment or a percentage coinsurance;

81. Amount attributed to periodic deductible;

82. Copay or patient pay amount;

83. Amount exceeding periodic benefit maximum;

84. Information sufficient to determine if the patient payment was in relation to being above or below a deductible amount or out-of-pocket maximum threshold;

85. Amount attributed to coverage gap (i.e., information sufficient to determine if a Medicare Part D patient payment was within the Medicare Part D "donut hole," if applicable);

86. If applicable, information sufficient to determine if a co-pay coupon program or other patient assistance program was utilized on the claim, including a description of said program and the amount paid by the program; and

87. A list of all available fields and which of those fields have addressed any of the items listed above.